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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **LEAH R. SATORRE** **9636 Muroc Street** **Bellflower, CA 90706** **Registered Nurse License No. 470512** Respondent.	Case No. 2010-444 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about August 31, 1991, the Board of Registered Nursing issued Registered Nurse License Number 470512 to Leah R. Satorre (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2011, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Code section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with Code section 2750) of the Nursing Practice Act.

5. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

6. Code section 118, subdivision (b), provides that the suspension, expiration, surrender, or cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

STATUTORY PROVISIONS

7. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

8. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

9. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

10. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

"(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

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COST RECOVERY

11. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTUAL SUMMARY

Corona Elementary School

Arm Injury Incident

12. From on or about February 25, 2008, to on or about June 10, 2008, Respondent was assigned to Corona Elementary School. On or about June 3, 2008, at approximately 2:30 to 2:40 p.m., a child fell off of the monkey bars on the school playground. Two school aides attended to the student soon after he injured himself. Shortly thereafter school administrators arrived on the scene to assess the situation and assist the child. While this was taking place, Respondent was sitting in and/or standing next to her vehicle in the school parking lot, a short distance from where the child injured himself. The playground and the parking lot were separated by a chain link fence. Respondent made no attempt to attend to the child or to lend her nursing expertise or support to the staff assisting the child. The child's parents and paramedics were called to the scene. After the paramedics stabilized the child's arm, his parents took him to the hospital.

13. On or about June 4, 2008, V.B., Assistant Principal at Corona Elementary School, conducted a conference with Respondent regarding her failure to assist the child who fell on the playground the day before. On or about June 5, 2008, Assistant Principal V.B. wrote a memorandum to Respondent memorializing the content of their meeting. During the conference, V.B. noted that Respondent's contractual hours were for an eight hour day[1] and that her obligation was to provide health assistance to students and staff past the school day, if needed. The incident of June 3, 2008, happened well within the eight hour day. The assistant principal

[1] According to a letter written by a District Nursing Administrator, Respondent's 8 hour work day was from 7:30 a.m. to 3:30 p.m.

also reminded Respondent of her State and District mandated responsibilities, including the mandate that "[m]ajor emergencies such as accidents, illnesses, or crisis situations that require immediate attention are to be given first priority by the School Nurse at all times." V.B. directed Respondent to make herself available to provide immediate response to any student's urgent medical need in the future.

14. On or about June 12, 2008, Respondent wrote a memorandum responding to the assistant principal's memorandum of June 4, 2008. In the memorandum, she stated that "2 yard assistants were there to massage the boys [sic] arm for over 15 minutes, this is a major blunder in first-aid intervention to a broken arm." She also stated that her "stress due to the daily heavy load, [her] broken car and [her] doctors [sic] appointment had played a role in [her] intervention [in the incident]. Paramedics [were] on hand to stabilize the condition."

15. Respondent was later interviewed about the incident by Board of Registered Nursing staff. She stated that on the day of the incident, she signed out of work at 2:40 p.m. She stated that she had a history of high blood pressure and that she felt ill and dizzy all day long. She said that she exited the school building after signing out and went to the parking lot where her vehicle was parked. She said that her vehicle would not start. She stated that while she was sitting in her vehicle, she noticed a child crying on the playground. She stated that she observed two yard assistants massaging his shoulder and arm area.

16. Respondent stated that she watched the two playground assistants assisting the boy for approximately 10 to 15 minutes. Respondent stated that when another school employee came by her vehicle, she asked him for the school address and then called the Auto Club and waited in her vehicle for them to arrive. Respondent stated that while she was waiting for the Auto Club to arrive, she noticed that other administrators had arrived to help the student. She stated that the situation did not appear to be urgent and that she felt that the student's crying indicated that his airway, breathing and circulation were "fine".

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Maywood Academy High School

Diabetic Shock Incident

17. From on or about September 5, 2006, to on or about June 20, 2007, Respondent was assigned to Maywood Academy High School. While assigned as the school nurse at Maywood Academy, Respondent was charged with testing a diabetic student's blood sugar prior to lunch on a daily basis. Respondent stated to the Board investigator that she "would contact a student's parents and send the student home if the blood sugar was above 250." Respondent also reported that when the student had a high blood sugar reading, she was to report the findings to the school administrators.

18. On or about May 9, 2007, Respondent was called to the diabetic student's classroom. Respondent reported to the Board investigator that when she arrived, the student was already limp and faint. Respondent reported that she took the student to the health office where she "tested the student's blood sugar and may have administered insulin."

19. Eventually, the student passed out and paramedics were called to the scene. By that point, the student's blood sugar was up to 400 mg/dL and the paramedics informed the school staff that the student was going into shock. The paramedics checked Respondent's nurse's log and it showed that the student's blood sugar had been measuring at over 300 mg/dL for several days. The paramedics informed the school staff that a blood sugar of 300 "is a dangerous level and should be taken very seriously." After being stabilized by the paramedics, the student was hospitalized and was out of school for about a week.

Provision of Unauthorized Medications/Substances to Students

20. Respondent reported to the Board investigator that while she was at Maywood High School, she would purchase nursing supplies and cold and flu remedies for use in her post as school nurse. Students reported that Respondent administered to them cough drops, tea, instant cup of noodles, cookies, hot water with salt, hot water with dissolved chicken bouillon cubes and green mouthwash. Students also reported that Respondent gave them sanitary napkins but charged them $0.50 for each sanitary napkin used.

21. On or about January 29, 2007, Respondent submitted receipts to the school for reimbursement for the nursing supplies that she purchased and administered to the students. On one of her reimbursement submissions, she attached three receipts from the "99 Cent Only Store" that listed the following items: cough drops, bottled water, soda, cookies, instant soup, ginseng tea, candy, chicken bouillon cubes, a sore throat remedy, jasmine tea, "Imodium" Anti-Diarrheal Mint, blueberry bars and apple bars. On the reimbursement submission, next to the receipts, Respondent wrote: "These were food items and remedies I bought for students use in the health office since October up to now. The sanitary napkin funds is [sic] not enough. Water in the faucet is not safe to drink, cookies is [sic] for students that come after lunch period and did not eat lunch. Tea is for stomachache, cough candies is [sic] for their allergies and mild sore throat. It really helped the students than [sic] being sent home. [¶] I hope I can get a re-imbursement [sic] and now I ran out of cough candies. Lots of students have seasonal allergies."

22. On or about January 30, 2007, Marilyn Boring, a Los Angeles Unified School District Nursing administrator, and the principal at Maywood Academy conferenced with Respondent about her administration of over the counter cold and flu remedies to students. Ms. Boring advised Respondent that none of the products should be at the school without physician prescription and parent signature. She also advised Respondent that she was jeopardizing her Registered Nurse License by providing those items to the students.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

23. Respondent is subject to disciplinary action under section 2761, subdivision (a), subparagraph (1) of the Code as defined in California Code of Regulations, title 16, section 1442 in that she engaged in conduct that constituted an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Complainant refers to, and by this reference incorporates, the allegations set forth above in paragraphs 12-16, inclusive, as though set forth fully.

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SECOND CAUSE FOR DISCIPLINE

(Incompetence)

24. Respondent is subject to disciplinary action under section 2761, subdivision (a), subparagraph (1) of the Code as defined in California Code of Regulations, title 16, sections 1443 and 1443.5 in that she does not possess and/or failed to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse. Complainant refers to, and by this reference incorporates, the allegations set forth above in paragraphs 12-22, inclusive, as though set forth fully.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

25. Respondent is subject to disciplinary action under section 2761, subdivision (a), in that she engaged in unprofessional conduct. Complainant refers to, and by this reference incorporates the allegations set forth above in paragraphs 12-22, inclusive, as though set forth fully.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 470512, issued to Leah R. Satorre.

2. Ordering Leah R. Satorre to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

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3. Taking such other and further action as deemed necessary and proper.

DATED: 3/18/10

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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